This report presents observations and conclusions on the free clinics operating in Chicago, and offers generalizations on the free clinic movement in the United States, as well as its relation, present and potential, to the changing health care delivery system.

Free Health Centers: A New Concept?

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Introduction

A "new phenomonen appeared on the national health care scene in the late sixties. Dubbed "the free clinic movement" by its supporters, termed "do-it-yourself medicine" by its detractors, and characterized as store-front medicine by neutral observers, this movement has attracted considerable attention in recent months. Several articles and papers have been published on the subject and free clinics have been the topic of discussion at professional meetings.[1,7]

About 175 clinics comprise this movement in the United States with one-third of them operating in California and the remainder in 31 other states.[8] About a dozen of them are currently functioning in the city of Chicago and while the author's observations and conclusions are general, the free clinics in Chicago provided most of the information and insights on the subject.

Basic Philosophy and Principles of the Free Clinics

There are variations between the Chicago clinics in the services they provide, their staffing patterns, the availability of funds, the nature of the referral relationships, etc., however, they all share common principles about health care. In a document prepared by the People's Health Coalition, a now disbanded federation of six of the original Chicago clinics, the authors expressed their basic philosophy as follows:

> . . . .From our experience with our health problems and with the continuing failure of most established institutions to solve them, we have arrived at a number of basic principles. The programs that have been initiated by the Coalition have shown that the following principles can form a sound basis for the evolution of a new health care system—a program of heath care for the sake of people's needs, not for the sake of market place profits. . . .[9]

Summarized, the principles are: 1) Health care is a right and must be free at the point of delivery; 2) the community served must have the controlling interest in the planning, organization and administration of the clinics; 3) humanity, dignity and concern for the patient must be the mode in which health care is delivered; and 4) the present health care delivery system is a failure and the free clinics offer a model for a new health care delivery system.

Organization and Background of the Chicago Clinics

The Chicago clinics were sponsored, organized or assisted in their formation by a variety of groups ranging from the Salvation Army to the Black Panther Party as is described in Table 1. As will be noted from the table, at least two of the clinics have been operational more than four years. Both of these are community sponsored clinics. Several of the others have been functioning for longer than two years. Most of these were sponsored by politically-oriented organizations. Complete information was not available for all the clinics but at least two others not described in Table 1 have also been serving patients for between two to four years. Amost all the clinics were assisted in the early stages of their development, as well as currently, by health science students who had been active in the Student Health Organization and by health professionals who have been active in the local chapter of The Medical Committee for Human Rights.

Unlike other free clinics, notably those in California, central focus of the Chicago clinics is care to the poor and minority groups. The Chicago clinics, while concerned about drug abuse and students' health problems, do not make services in these areas their main emphasis.

With the exception of one clinic housed in an Infant Welfare Station after regular hours, the clinics are generally located in make-do facilities, that is facilities that were not intended for health care delivery. Remodeling, renovation and equipping of the available space was undertaken by volunteer workers from the community, some health workers, and sponsoring organizations. These people transformed the original areas into bright, pleasant, or plainly functional health care facilities.

The clinics are usually open only a few nights a week or on a Saturday but none is open a full week. Supplies and equipment are donated for the most part although some things are purchased if they are not otherwise available.

Clinic Staffing

All professional and lay staff are volunteers, with the exception of one clinic director who receives a very modest stipend from a church group. The professional staff includes a number of health science students and their work in the clinics is usually not part of their formal medical of nursing education but results from personal beliefs and commitments. Many of the volunteer physicians are young house staff officers from institutions around the city. They, as well as some older physicians, donate a night or so a week to working in a free clinic. The younger physicians are divided in their reactions to the clinics. A few of them

Table 1—Descriptive Information, Several Chicago Free Clinics

Name of free clinic	Initiating groups	Physical plant	Service area	Ethnic-racial	Date
Community Health Center of Englewood	Community residents Health science students	Salvation Army Community building	Englewood - South Side	Black	5/68
Robert Taylor Homes Health Clinic	Community residents Health science students	Board of Health Infant Welfare Sta.	Near South Side	Black	7/68
Young Patriots Uptown Health Service, Inc.	Young Patriots Organization	Space in Y.W.C.A. Building	Uptown Area North Side	Predom. Appal. White	11/69
Spurgeon Jake Winters Free Peoples Medical Care Ctr.	Black Panther Party Med. Committee (MCHR)*	Remodeled store-front	No. Lawndale West Side	Black	1/70
Dr. R.E. Betances Health Program	Young Lords Org. Health science students	Church	West Lincoln Pk. Mid-north side	Predom. Puerto Rican-American	2/70
Benito Juarez Peoples Health Center	Community residents Health science students	Settlement house	Pilsen Area Near-west side	Predominantly Mexican-Amer.	5/70
Pedro A. Campos Health Center	Latin-American Defense Org.-students	Storefront	West Town Northwest side	Predom. Puerto Rican & Mex.Am.	5/70

Sources of Information: Documents prepared by The People's Health Coalition, February 1970; Benito Juarez Project Proposal (date of preparation not known); The Chic Health Research Group and Urban Training Center, September 1971; Chicago Health Struggle, August 1971

Information for other free clinics was not available at the time the table was prepared

* The Medical Committee for Human Rights, Chicago Chapter, was involved to a lesser or greater degree in the initiation of each of the clinics described.

have been "turned on" to the extent of leaving their residencies to volunteer full-time in the clinics, supporting themselves by emergency room work or other part-time endeavor. Others, however, have reduced or discontinued their time in the clinics because young, not fully trained physicians are often uncomfortable practicing medicine outside their hospitals' protective environment. There are sometimes inter-personal communications problems between usually middle class, white, well-educated physicians and black or other minority poor who use the clinics' services or who administer them.

Nursing personnel are also volunteer but many nursing functions are performed by community or organization volunteers who have been trained or who learned to perform many of the tasks in the clinics which nurses might perform in other settings. Laboratory technicians who perform simple procedures, such as CBCs, routine urinalysis, etc., are also trained from among community or organizations volunteers with volunteer medical technologists acting as teachers and supervisors.

The clinics all have a patient advocate system. Advocates are drawn from the community or organization personnel. In most of the clinics, the patient advocates are perceived as the protectors of the patients' rights and as interpreters of the patients' needs to the professionals. They also translate the professionals' instructions to the patients and they assure follow-up in patient management. Frequently, they transport patients to and from medical services, they act as home health aides and they tend to be the organizers and managers of community out-reach programs where there are such. In a few clinics, the patient advocate functions in a more limited role perhaps only inquiring into the patients' satisfaction with the services of acting as social workers would in expeiditing patient management.

The type of staffing lends itself to implementation of the principle that care should be rendered with humanity and dignity and with concern for the patient. In those occasional instances where it is thought that a staff member has not acted in a humane fashion or has been "elitist" in his approach to his patients or colleagues, the matter is usually called to attention sharply by colleagues or the clinics' administrators, not usually by patients if the offender is a physician.

Control of the Clinics

The Chicago clinics are administered by the people who organized them initially with varying degrees of dependence upon health professionals. In the cases where a community group initiated the clinic, that group has continued to determine the policy and direction of the clinic. Where the initiating body was an organization, the administration has remained in the control of that organization. Some of the clinics encourage participation by health professionals in their function and administration. However, there are extremes of views among the leaders of the clinics with a few espousing the view that only the people using the clinic can plan their own health care since only they know how bad their health care situation has been and are competent to correct the problem. At the other extreme are the few leaders who rely heavily on professional advice, especially that

of physicians. Most of the clinics are somewhere in the middle of the spectrum and either include health professionals as members of Boards or Advisory Committees or health professionals are part of the collective which runs the clinic. The leaders who have the greatest responsibility for the administration and policies of the clinics however are always the community or organizational sponsors of the clinics.

All the free clinics jealously guard their free-standing status. They are wary in their dealings with health care institutions for fear that attempts to achieve tight referral arrangements may lead to take-overs by the institutions thus replacing their control with institutional control. While they all seek referral ties with institutions (to be discussed in more detail later) they maintain themselves as free standing units and do not wish to become out-posts of other institutions.

Scope of Services

Table 2 presents data for the number of patients seen or visits served over a specified period of time. Every clinic has all the patients it can care for, and more.

The services vary from the kind that would be available in a first-aid station to more comprehensive care for pre-natal patients, well and sick baby care and treatment for colds, minor infections and other self-limiting ailments. Prevention and detection programs are sponsored by some of the clinics. The Black Panther Party Clinic tests for sickle-cell trait among children in several schools located in their area. Pregnancy and venereal disease testing are available at some of the clinics as are immunization and family planning services. Some home health services are provided but in a very limited fashion by one or two clinics. Most of them would like to offer broader prevention and detection services but are limited in what they can offer by a number of factors, but especially by financing and manpower constraints.

Referral resources are loosely defined. In one of the clinics, however, specific arrangements are contractually established between that clinic and a major medical center. The medical center provides drugs, supplies and equipment to a maximum of $1,000 per month. Patients are referred, as necessary, to the Center's outpatient and inpatient services. Fees are waived at the Center for patients unable to pay. This arrangement was achieved by pressure exerted by students attending the Medical Center's schools and leaders of the local organization which started the clinic. When they joined forces, negotiations with this medical center were facilitated.

In other cases, negotiations between other clinics and other centers have not been as productive. There was considerable resistance to several of the other clinics on the part of medical institutions. In some cases where their resistance was minimal, demands by the clinics seeking referrals escalated that resistance. In a few cases confrontation situations resulted with varying degrees of response by the institutions.

In clinics where there are no referral arrangements with institutions, the patients are dependent upon the

Table 2—Registered Patients and Patient-Visits in Several Free Clinics in City of Chicago

Name of free clinic	Over period of time (in months)	Number of patients registered*	Number of patient visits	Patients seen in one week, April '71
Benito Juarez Peoples Health Center	14	1,300	3,000	N.A.
Community Health Center of Englewood	33	12,000	N.A.	N.A.
Robert Taylor Homes Health Clinic	34	10,000	N.A.	50
Young Patriots Uptown Health Service, Inc.	22	4,000	N.A.	N.A.
Spurgeon Jake Winters Free Peoples Medical Care Center	14	1,400	N.A.	75
Dr. R.E. Betances Health Program	12	1,200	N.A.	50
Pedro A. Campos Health Center	15	2,000	N.A.	50
Fritzi Englestein Free	13	1,300	N.A.	130

* Patients visiting the clinic at least once

Sources of Information: Vincent K. Pollard, How Many Patients Do Chicago's Free Clinics Serve?, Chicago Health Research Group, September 1, 1971; The Peoples Health Coalition, February 1970; Chicago Health Struggle, No. 5, August 1971; Personal Communication.

physicians who volunteer in the clinics to either refer them for care to hospitals where they have staff privileges or to other physicians or institutions where the patient will be seen. However, whether the patient then ever returns to the clinic has not been studied.

Impact on Health Care

There is evidence to suggest that the free clinics have had some impact on health care in Chicago. The sponsors assert that they have exerted an influence beyond their own service contributions on provision of care to minority and poor communities. They cite the planning or operation of new health care facilities by the Chicago Board of Health and contend that these, if ever implemented, will be directly attributable to the existence and activities of the free clinics.

In the past two years or so, the Board of Health has proposed the building and eventual operation of eight neighborhood health centers located in poor communities. The Board avers these are part of a city-wide health care plan devised by them to fill the gap in availability of comprehensive medical care services despite the fact this is neither the Board's charge nor its area of expertise.

The free clinics' spokesmen point out that four of the proposed Board centers are suspiciously close to the location of four of the free clinics and would never have been planned were it not for the free clinics mere existence.[10] To date, only one of these Centers has opened offering limited services in a Model Cities target area, Uptown, where the Young Patriots Clinic has been located. This is one of the most active of all the clinics in terms of patients served and community activity. Another Board center was scheduled to open, also in a Model Cities area, but apparently has not opened to date due possibly to a court-ordered freeze on Model Cities funds in Chicago. However, no free clinic is located near this particular center.

Unique to Chicago has been the on-going battle between the Chicago Board of Health and the free clinics. This has not occurred in other cities where, for the most part, the free clinics are simply ignored by the political leaders.

In Chicago, an antiquated city ordinance was used to haul leaders of a free clinic before a magistrate. The magistrate refused to rule against the clinic and it continued to function. Then the old ordinance was revised and introduced in the city council by the Mayor of Chicago. Among other provisions, the ordinance required all clinics, not administered by physicians, to register with the city and make their patient and other records available for inspection by Board of Health personnel at their discretion. The clinics viewed this as potential harassment of their patients and as treating them differently from other clinics. The Board of Health claimed it sought only to regulate clinics to assure their patients of quality care. The clinics retorted that the quality of medical care available in Board of Health Clinics was nondescript at best and they needed to set their own house in order before they could carp about the quality of care elsewhere.

The Daley political administration, long known for its exquisite sensitivity to criticism, is seen by clinic spokesmen and others as pursuing the goal of closing the free clinics because their existence is a source of embarrassment to them. A detailed description of the clinics' struggles with the Board of Health are found in other publications.[11,12]

Problems of the Clinics

In addition to their fight for survival, the clinics are plagued with a paucity of funds and manpower. To date, the free clinics have not been able to establish adequate or regular sources of funding, with the exception of one clinic. Some clinics have tried to recover payment for patients who are eligible for medical assistance from the Department of Public Aid but these attempts have been generally unsuccessful. In some cases, the physicians bill the Department for patients seen in the clinics as if they were private patients seen in their offices and, when the physician is reimbursed, he returns the fees to the clinic as a contribution.

There is an ambiguous response on the part of clinic supporters to the whole question of the funding of health services. Some sponsors take very little interest in the issue of the financing of medical care and are concerned only about their day-to-day financing problems. Some feel that the clinics are an example of how little medical care should cost since they manage to operate their clinics on a shoestring or hand-to-mouth basis and still manage to provide some services. These leaders, of course, overlook the fact that they are also running a shoe-string, hand-to-mouth level of medical care services.

A few of the clinics' leaders recognize the need to obtain and maintain stable resources but are not yet involved particularly in efforts to achieve major change in the financing mechanisms. Most continue to seek contributions catch-as-catch can for day-to-day operation.

Professional staffing, especially physician manpower, remains a problem. The ordinary difficulties in recruiting manpower are exacerbated for the clinics since all staff is voluntary. The number of young physicians willing to volunteer precious time in the clinics is still not large despite the emergence of the "new breed" of socially conscious medical students and house officers. These are still very much in the minority although there are many more than there were a decade ago. Those who do volunteer their time have full-time training and practice commitments as well and therefore cannot find more than a few hours per week to donate to the clinics. Some of the clinics are developing programs less dependent on physician personnel but since the Chicago clinics are under the eyes of especially watchful authorities, it is always necessary that there be at least one licensed physician on the premises if patients are being seen.

Comments

The clinics' organizers and sponsors maintain that theirs is a new model of delivery of care because their care is delivered free to the patient at the point of delivery and that in the hands of the people rests the decision-making power over the clinics' policies and programs. These assumptions need to be examined realistically rather than romantically.

The concept of "free" care is not exactly a new one. Modern major medical institutions have their roots, in

many instances, in free clinics. For example, the Central Free Dispensary, a progenitor of one of the country's leading medical centers in Chicago, stated its initial purpose, when formed in 1865 was

> . . . .to furnish free and part-free medical care to individuals in this community who are unable to pay a private physician. . . .[13]

The Dispensary's by-laws, developed in 1873, almost one hundred years ago, state that their object was

> . . . .to aid persons who are sick and unable to pay for medical attention and to do this work efficiently and with no pecuniary profit. . . .[14]

Many other outpatient departments and hospitals began, as did the Central Free Dispensary, as small clinics offering free or part-free medical care, utilizing volunteer staff and dependent upon gifts and contributions for their support.

The tragedy is that one hundred years later, poor people are still trying to obtain adequate and satisfactory health care by organizing free clinics with volunteer staffs dependent upon gifts and contributions for their support. Health care is still not readily available to the poor and indeed is becoming less available to middle-income groups as it becomes more costly, fragmented and suffers from manpower shortages. The present health care system has failed to reduce excess non-white infant deaths. It has failed to effectively combat the high tuberculosis and venereal disease rates, and other preventable and unnecessary illnesses that continue to plague the poor, the black, the Spanish-speaking and the Indian. The free clinics have been forced, by the failures of the system, to try and create their own solutions to these problems, but whether the organization of free clinics in the mode of 100 years ago is the best solution is open to question.

The struggles to win a system where health care is free at the point of delivery are also at least a half century old.[15] These struggles have not been successful to date, but there is certainly indication that the future holds some form of national health insurance programs and the nature of those programs may well be determined by the input of the free clinics in conjunction with broader forces who can help mold the legislation that brings new and better financing mechanisms into being.

The concept that decision-making should be in the hands of the people who consume health services is also not completely new. A portion of the "public" has always been involved in decision-making. This group has usually included civic leaders, industrialists, bankers, etc., whose membership on Boards of Trustees of health care institutions is well-known. Traditionally, organization and delivery of care has rested with health professionals, government, educators and those just mentioned for the public. Planning and delivering health care for the poor has excluded the poor. Now, this tradition is being challenged. The challenge is in step with our times when the legitimacy of all our social institutions is generally in question. "Power to the People" is the mood of the day in the health depressed communities served by the free clinics and the free clinics are one expression of that mood.

Hopefully, health professionals will recognize that the concept of public involvement is a sound one, whether the community is poor or rich, white or black, powerful or powerless. The community's assessment of priorities in health care delivery and the models of delivery is vitally necessary to the organization of sound health care models. Equally vital to the development of sound models is the experience of the health professionals. The advocates of community control and the health professionals who seek change should be looking for common ground to work together in achieving their mutual goal—the development of new and more responsive delivery models.

The clinics offer a base for creating change. They have the ability to mobilize numbers of people around health care issues, something professionals cannot do, in the areas where they provide services. The fact that they provide care gives them a base for education and involvement of their communities. However, the problems in providing that care sap their energies and limit their potential for mobilization of the resources of their communities to seek change. Some clinic spokesmen assert that they have already created change, but one only need look at where the vast majority of health services are rendered and where the greatest numbers of people are affected to recognize the limited nature of their change. While the free clinics served thousands of patients in the past few years, three establishment outpatient clinics in Chicago had nearly three-quarters of a million patient visits last year alone and this excludes all other institutions providing such care and emergency room visits in all institutions. One major purveyor of care to the indigent and medically indigent sees 1,000 patients daily in its outpatient clinics, and again, this number does not include the numbers seen in their emergency room or admitting and screening areas. Thus, pressure on the present system for change may be just as necessary as the development of alternative models outside the system.

Conclusions

The free clinics were organized in response to a chronic need for more adequate health care provided with humanity and dignity and primary concern for the patient rather than the convenience of the provider. They are one facet of a scene rich in potential for building models that will meet this need.

Community health networks are in the planning stages, health maintenance organizations are being established, new financing bills are being introduced into the federal and some state legislatures, community interest in health flourishes and more health professionals understand the importance of the community's role in health delivery. Much activity is underway on all fronts for the remodeling of the health care delivery system.

The free clinics should be participants in these activities by invitation, inclination or insistence. All health professionals concerned about the conditions which gave rise to the free clinics should be seeking alliances with communities and other forces in order to change these conditions. There need not be total agreement between them on all solutions to all problems—there need only be agreement that an inert, moribund health care system must be changed into a dynamic, responsive and responsible one. Sponsors of the free clinics as well as other health providers must recognize that no one group has a monopoly on solutions. Multiple approaches by multiple forces are indicated and

healthy. It may not be possible to evolve a new, sound health care system in an old social order, as the free clinics and many health professionals would desire, but every effort should be made to change the present system to improve its quality and accessibility. Whether the free clinics are a new concept or not, they are part of a continuum of struggle and change that must proceed.

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